HMO, on average, costs 13.2 percent more than if it were provided through traditional Medicare.

So I question, as we have precious few dollars to work with to be able to provide the services and the care for which our seniors are asking, the wisdom of moving to a model that is rising in cost faster than Medicare. I have not seen evidence where, in fact, it will provide the kind of competition to lower the prices, which we are all looking for from the private sector at this time. In fact, what I am hearing from the business community is they want us to partner more with them, the public sector and the private sector. Because we now have our global economy and businesses competing around the world and because we are the only employer-based health insurance system among the industrialized countries, they find themselves at a competitive disadvantage and are asking to partner with the private sector to both contain costs and be able to help them compete and continue to be able to provide insurance coverage.

So in light of all of these discussions that are going on, we look at Medicare, which is the one piece of a health system that Congress in its wisdom back in 1965, along with the President, said we are going to make sure is available, universal, once one is 65 or if they are disabled, regardless of where they live; if they are in the Upper Peninsula of Michigan, Detroit, or in Benton Harbor, they know they will be able to have insurance coverage, be able to choose their own doctor, be able to get the care they need. They know what it costs. They can count on it. That is the miracle. That is the reason so many seniors overwhelmingly choose traditional Medicare rather than other private sector options.

So we come to the difficult choice now of how to provide prescription drug coverage, and there is a difference of view certainly about whether we should strengthen traditional Medicare or provide incentives, encouragement, a carrot stick—whatever one wishes to call it—for those to go into managed care. I commend my colleagues for attempting to find that balance in the middle. I believe the balance really is not struck unless we make sure that traditional Medicare is part of that choice.

I also am very concerned that we hear constantly that, in fact, we have a situation where we can only afford to go a part of the way. It is my understanding, when all is said and done, we are talking about providing most seniors—certainly middle-income seniors—with 20 or 25 percent to help with their drug bill over time. I do commend the structure for low-income seniors, but overall we know we are not providing a comprehensive prescription drug benefit with the dollars involved. It is half of what it would take to provide the same coverage we have as Senators through Blue Cross and Blue Shield under the Federal employee health system. So we certainly are not providing what we, other Federal employees, receive for a comprehensive benefit.

I have often heard, well, we cannot afford to do that. I feel it necessary to indicate for the record one more time why it is we are talking about a system that is not comprehensive, will end for several months of the year for seniors, will not provide them what they need, and is complicated and convoluted, I believe, and that is because of another set of policies that were debated in this Congress not long ago, coupled with what happened in 2001, and that is the question of making a determination, a value judgment, that it is a bigger priority to provide tax cuts for the wealthiest, the privileged few of our country, rather than helping the many of our seniors and the disabled to be able to put money in their pockets through prescription drug coverage.

It is astounding to look at what that decision has done. We are told that the 2001 tax cuts made permanent and the other proposals passed over the next 75 years will, in fact, cost $14.2 trillion, where the projected Medicare and Social Security deficit combined—not just Medicare but Medicare and Social Security deficit—is $10 trillion.

This has been a conscious choice to make a decision to spend dollars in one way to help a few people in our country rather than to keep the commitment of Social Security and Medicare that we have had for many decades in our country. The fact that we are talking about an inadequate benefit that ends, that leaves coverage gaps of 3 or 4 months a year for our seniors, the fact that we are talking about an approach that does not do what they have asked us to do, is because of decisions made to take revenue and instead of investing it in health care for older Americans, instead of investing it in strengthening Social Security for the next generation, the decision was made to eliminate that revenue.

By the way, that decision has resulted this year in the highest single-year deficit in the history of our country. Unfortunately, a hole has been dug. I fear it will continue to be dug deeper and deeper with the decisions that will be made.

It is not too late to decide in this debate we will do it right—real choice, a real benefit—that we make decisions that are best for the majority of the people we represent. They are counting on us to do this right.

RECESS

The PRESIDING OFFICER. Under the previous order, the hour of 12:30 p.m. having arrived, the Senate will stand in recess until the hour of 2:15 p.m.

Thereupon, the Senate, at 12:30 p.m., recessed until 2:15 p.m. and reassembled when called to order by the Presiding officer (Mr. VOINOVICH).

The PRESIDING OFFICER. The Senator from Utah.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

Mr. BENNETT. Mr. President, I ask unanimous consent that for the duration of today's session, S. 1 be available for debate only, with the time until 6 o'clock today equally divided as under the previous order.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, it is clear from this unanimous consent request that we are waiting for CBO scoring on the Medicare bill. That, it is my understanding, will not be in until very late tonight. So as I understand this unanimous consent request, if we extend the time past 6 tonight, it still will be for debate only on this matter; is that right?

Mr. BENNETT. I say to the Senator, my understanding is the same as his, but I am not in any position to make a commitment.

Mr. REID. I would advise Members I don't think they can expect at 6 o'clock to start offering amendments. I don't think the bill will be ready at that time. So if we do go past 6 o'clock, I am confident it will be for debate only.

But I agree to the request at this time, that until 6 o'clock today the time be equally divided as requested by the Senator from Utah.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, if I could, through the Chair, ask the Senator from Utah if the Senator from Utah is going to speak on the bill at this time?

Mr. BENNETT. That is correct.

Mr. REID. I ask unanimous consent that following his statement the ranking member of the Budget Committee, Senator CONRAD, be recognized to speak on this legislation now before the Senate.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The Senator from Utah.

Mr. BENNETT. Mr. President, we are debating the substance of the bill that came from the Finance Committee with respect to a prescription drug benefit for Medicare. We all recognize that providing a prescription drug benefit for Medicare is long overdue, something that has been needed badly for a long period of time. I am heartened by the bipartisan nature of the vote that came out of the Finance Committee.

I am reminded of an occasion when I first came to the Senate and we began debating health care. I fell in step with the then-chairman of the Finance Committee, Senator Moynihan from New York. Senator Moynihan is one whom I met when I was first serving in the Nixon administration and he was serving as the domestic counselor to President Nixon. I felt close to him from then on.

As we walked through the door into the Chamber, I said to him: Pat, do you think we are finally going to get some health care reform this year?

And he said: Yes, I do. In the Nixon administration the President wanted it and the Democrats in the Congress said no. Later on—I believe he referred to the Carter administration—the President wanted it and Republicans in the Congress said no.

He said: This time, the President wants it and the Congress wants it and I think we are going to get it done.

He turned out not to have been right in that instance, perhaps one of the few times in his life when his reading of the political tea leaves was incorrect because we fell into wrangling. It was on some issues that were worth wrangling over, I do not want to suggest they were not, but that prevented us from focusing on the core question of whether our health care circumstance in this country needed to be improved.

Fortunately, we have now focused on the overall question of should we or should we not have a prescription drug benefit for Medicare. At least coming out of the committee, we have a strong bipartisan consensus that we should. The reason we should is very clear, if you look at the way we practice medicine.

Medicare was adopted in the 1960s, and it was patterned after the best Blue Cross-Blue Shield fee-for-service indemnity plan written in the 1960s. Now it seems that plan has been frozen in time for 40 years. Unfortunately, it has not had the regulatory flexibility necessary to deal with the changes in the way medicine is practiced. It has required Congress to step in and make those changes. As Congress has done so, Congress has demonstrated that it is slow and it can be bogged down in political challenges that prevent changes being made.

By contrast, if you go to FEHBP, the Federal Employees Health Benefit Plan, under which we and other Federal employees are covered, you find a degree of regulatory flexibility that allows the people who administer the plan the capacity to move and change quickly as the medical situation changes. Congress is not required to debate these changes and, therefore, hang them up on political considerations. That is one of the reasons why the FEHBP has been more effective in providing health care services to those who are parties to it. Clearly, we in Congress need to finally catch up to the reality that the Medicare system is outmoded and structured upon a program that desperately needs to be updated.

Back in the 1960s, the primary concern people had with their health care was the cost of going to the hospital. You went to the hospital for almost every major circumstance. Now we find through research funded by Government, through research funded by the drug companies, and products that have emerged from that research, that many of the sicknesses you used to go to the hospital for and stayed for 3 or 4 days can be taken care of by taking a pill. Yet Medicare says if you go to the hospital and run up a bill of however many tens of thousands of dollars to stay that many days, we will pay for it. But if you take the pill that makes the hospital visit unnecessary, we will not. That clearly doesn't make sense. There is the need for the benefit of prescription drugs, and the Medicare system needs to catch up to that circumstance.

The bill that emerged from the Finance Committee encourages competition between plans. It provides us a first glimpse of breaking the lockstep mentality Medicare has had since the 1960s. It gives us an opportunity to experiment with some competition injected into the system. One of the interesting aspects coming out of this debate is the difference in expectations on the part of those who are supporting it. There are those on the left who are supporting this, saying this is just the beginning, and if we get this established, we can see a massive increase of governmental programs to bring prescription drugs to seniors. There are those on the right who are supporting it who are saying this has the degree of competition in it that will bring market forces into Medicare in such a way that we will see a massive increase in the amount of competition and the amount of market influence on holding down costs.

For both sides, this is a great leap of faith. Neither one knows whether the other is right. Neither one knows exactly what will happen. I suppose 5 years from now when the Congress gathers we can look back and say, Yes, we were right injecting a sense of competition into the bill. It has produced tremendous benefits, brought costs down, and made things more efficient. Or we might see people look at us saying, Yes, we were right passing the bill. It did bring about a major new expansion of Federal support for prescription drugs. We will have to wait and see.

But the necessity of getting a drug benefit for Medicare is driving the leap of faith on both sides. It is bringing us together in a way we haven't seen in this debate in the past.

Obviously, I am one who believes competition creates market efficiencies, and that the experiment will work in the direction of getting more competition and more efficiency rather than in the direction of getting more government involved. It is a leap of faith for me.

I share the concern of what can happen to the cost. We know Federal programs never cost what they are projected to cost. They always cost substantially more, particularly entitlement programs. For me and others who hold that view to embrace this bill and say we are willing to take this leap of faith is indeed, I think, a fairly significant step.

But I come back to the point I made at the beginning. We cannot continue to sustain a Medicare Program that does not recognize the role prescription drugs now play in the way medicine is practiced. Even though it is a huge risk to move in the direction this bill represents, it is not as great a risk as allowing the status quo to remain and proceed any further. Medicare needs to be brought up to date. This is by no means the amount of bringing up to date I would support or that I have called for here on the floor. But it is a final recognition of the fact that Medicare is outdated, that changes need to be made, and for that reason I will take the step.

I commend members of the Finance Committee on both sides of the aisle for the careful and thoughtful way they have approached this challenge. I commend them for crafting a bill that, as I say, holds out some hope for everybody in the spectrum. But I hope they will continue to address this question with as open a mind as possible and with the firm understanding that however sacred the word Medicare is in our political lexicon, the details of the program should not be sacred but should be brought up to date at every possible opportunity to conform with the reality of the world in which we live.

I yield the floor.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. CONRAD. Mr. President, I rise to discuss the prescription drug bill and the Medicare reform package that is before us now. As a member of the Finance Committee, I was involved in the markup of this legislation.

Let me begin by commending the chairman, Senator GRASSLEY, and the ranking member, Senator BAUCUS, our former chairman, for the way in which they brought our committee together. That was not easy to do. It is an extraordinarily complex undertaking to have an expansion of Medicare of this magnitude and to do it in a way that will achieve real results.

I thank the chairman and the ranking member for the way they brought us together, and for the tone they set in the committee. We were in markup from 9 in the morning until 9 o'clock at night—12 hours of togetherness that actually went very well.

I think we all know why we are here. When Medicare was first drafted, the world was a very different place in terms of providing health care. As Senator Moynihan used to explain, at the time Medicare was drafted, the Merck Manual that contains all prescription drugs was a very thin volume. Now when we look at the Merck Manual, it is a very weighty tome. There is a dramatic change in the pattern and practice of medicine. Perhaps no better example is what happens with stomach illness. Twenty years ago, there was not much one could do for somebody who suffered from ulcers other than to have surgery. But now with prescription drugs that address the underlying causes, stomach surgery has been reduced by two-thirds. Yet, in Medicare there is no coverage for those prescription drugs. You can't have a modern Medicare without a prescription drug component.

The problem is millions of Americans don't have any coverage. If we look at an outline of where we are, we see that 38 percent of those who are Medicare eligible have no drug coverage. Ten percent get their coverage through Medicaid, 15 percent through a Medicare HMO, 28 percent employer-sponsored coverage, 7 percent Medigap, and others, 2 percent. But nearly 40 percent have no coverage.

That creates some very tough situations. And we can see there are real differences between where somebody lives, how old they are, and their income level, as to whether they are in that nearly 40 percent of Americans who have no coverage. We see for those over the age of 85, 45 percent have no coverage. For those who live in rural areas—and I represent a rural area, the State of North Dakota—50 percent have no coverage. Forty-four percent of those who have between $10,000 and $20,000 of income have no coverage.

What we see is the situation is going to become more challenging and more difficult as out-of-pocket expenses for prescription drug expenditures jump dramatically. In 2000, those out-of-pocket expenditures averaged $644. By this year, it was up to $999—a 50-percent increase in just 3 years. And in the next 3 years, we anticipate another very large increase to $1,454 a year in prescription drug costs.

The implications of that are outlined on this chart. This shows a study in eight States. It shows the percentage of seniors who reported forgoing needed medicines, and that is listed by chronic condition and prescription drug coverage.

What it shows by the red bar is those without coverage, and it shows the percentage of seniors who did not fill prescriptions one or more times due to cost. For congestive heart failure, 25 percent of the people did not fill their prescriptions because they could not afford it; 31 percent of those who suffered from diabetes did not fill their prescriptions because they could not afford it; and 28 percent of those with hypertension did not fill their prescriptions because they could not afford it.

If we go to the next element of the chart, the percentage of seniors who skipped doses in order to make it last longer: For congestive heart failure, 33 percent of those without coverage skipped doses; 30 percent of those with diabetes skipped doses because they could not afford it; and 31 percent of those with hypertension skipped doses because they could not afford it. Obviously, that reduces the quality of care and ultimately increases the cost. Why? Because those people are more likely to be hospitalized. And it is when a senior is hospitalized that the cost really escalates.

I think it is in all our interest—both in terms of the quality of health care but also in terms of the cost of health care—that we get this right and we make the changes necessary to provide a prescription drug benefit in Medicare.

Here, outlined on this chart, are the specific provisions of this legislation. These are estimates of the basic plan which will take effect in 2006. This excludes the low-income subsidies. We will talk about that in a moment. The premium will average about $35 a month; at least that is the projection at this point. The deductibles will be $275 a year. From $276 to $4,500 of prescription drug costs a year, 50 percent will be paid by Medicare, 50 percent by the senior citizen. Between $4,501 and $5,812 of prescription drug costs a year, there will be no assistance from Medicare. That is the so-called coverage gap, what some refer to as the ''doughnut.'' This is an area in which there is no assistance, no coverage. The reason for that is not enough money. For $5,813 and above in prescription drug costs, Medicare will provide 90 percent assistance, the senior citizen 10 percent.

I think that is one of the most important parts of this bill. I would support this bill if there were no other provision than just this one. To provide 90 percent assistance to those who have catastrophic drug costs is going to make a meaningful difference.

I was just with one of my staff members in North Dakota. Her mother had a rare form of cancer. At one point her drug costs were running $20,000 a month—$20,000 a month. Thankfully, she was insured. As we see, nearly 40 percent of seniors in the country are not. How many families could withstand a drug cost of $20,000 a month? For this particular family, their drug cost now has been reduced. She is past the acute phase, thankfully. Their drug costs are still running $2,500 a month. That is $30,000 a year.

This provision will help people like that. It will keep people from bankruptcy. It will avoid people having to not have treatment. It will prevent crises in many families across the country.

That is not the only part that I think merits support.

As shown on this chart, these are the low-income provisions. I want to direct people's attention to this line. For those who are below 160 percent of poverty, they will get more assistance. So, for example, in that zero to $4,500 range of prescription drug costs, Medicare will pick up 90 percent of the cost for those low-income people. They will have to provide 10 percent of the cost. This, to me, is another strong reason to support this legislation.

A third key element of this bill that I think merits support—certainly for those who have rural areas—is the beginning of the leveling of the playing field between the rural areas and the more urban areas of the country.

Just to give an example, in my home State, Mercy Hospital in Devils Lake, ND, gets exactly one-half as much in Medicare reimbursement to treat a heart ailment or to treat diabetes as Mercy Hospital in New York City—exactly one-half as much. Now, I would be the first to acknowledge there is somewhat of a difference in cost, but it isn't a 100-percent difference. When we go to buy technology for that hospital in Devils Lake, ND, we do not get a discount. When we try to recruit a doctor, he does not say to us: Well, you are a rural area, so I will take half as much money. That is not the way it works.

So this incredible divergence, this disparity that exists in current law, needs to be addressed, and this bill will begin to address it. It does not close the gap, it does not eliminate the problem, but it does make meaningful progress. It permanently and fully closes the gap between urban and rural standardized payment levels. But unlike the legislation I introduced, it does not take effect until 2005. The legislation I introduced, along with 30 of my colleagues, would have taken effect in 2004.

It also adopts all of the other provisions of the bill that I introduced along with Senator THOMAS of Wyoming. It equalizes Medicare disproportionate share payments. Those are the ones that are used to cover the costs of treating the uninsured. It establishes a low-volume adjustment payment for small rural hospitals. It improves the wage index calculation which accounts for a hospital's labor costs. It ensures that rural hospitals are reimbursed fairly for outpatient services.

It provides a whole series of improvements to critical access hospitals, including improved payments for ambulance services, increased flexibility in the bed limit, excluding critical access hospitals from the wage index calculation for other hospitals, which will improve payments to other larger facilities, has new incentives to ensure 24-hour access to emergency on-call providers, and has new measures to assure the critical access hospitals will receive timely Medicare reimbursement. It also authorizes a capital infrastructure loan program which will provide $5 million in loans for crumbling rural facilities.

In addition, it provides a series of other provisions which a number of us have cosponsored and put before the body, including extending a 10-percent add-on payment for rural home health agencies, many of which are under pressure to close; a new 5-percent increase for rural ground ambulance services; a new 5-percent add-on for clinic and ER visits in rural hospitals; and a new automatic 10-percent bonus payment for physicians serving in rural areas.

It has measures to address the geographic inequities in physician reimbursement, and an extension of improved payment for lab services in sole community hospitals.

This does not close the gap between rural institutions and more urban institutions, but it does make meaningful progress in leveling the playing field, and that is critically important to rural hospitals.

Let me say, in my own State we have 44 hospitals.

At least eight of them are in danger of closing because of this enormous gap in Medicare reimbursement. Over 50 percent of their patients are Medicare eligible. If things don't change, these institutions are going to have to close.

Those are positive aspects of the bill. Let me speak for a moment about what is in the bill that could and should be improved. The first that comes to my mind is the instability in the legislation. Seniors want certainty. They want to know what they are getting. But under this plan, seniors could be bounced back and forth between different plans depending on how many private drug-only plans enter an area. That is the first problem. If a senior is in a fallback plan and two private plans enter the area, they must leave the plan they are in; they have no choice in the matter. The second problem is that every time they switch between drug-only and fallback plans, their benefits could change.

Let me illustrate that for my colleagues. Seniors, when forced to move between plans—and in 4 years, a senior could be forced into four different plans—every time, their premiums could change. The only thing that wouldn't change is the stop loss amount, or at least couldn't change. The deductibles could change. The coinsurance level could change. The coverage gap could change. The covered drugs could change. And the access to a local pharmacy at no extra charge could change. That is the kind of instability about which I am talking.

Let me illustrate with this chart. I hope my colleagues are listening, or at least for those who are busy with other duties, perhaps their staffs are listening. It is very important to understand what could happen to a senior. In 2005, if there is only one private plan offered in their area, they could enroll either in that plan or in the fallback plan. Let's say this particular senior takes the fallback plan and enrolls in that for 2006. But then the next year, another private plan comes into the area. Then the senior would be compelled to drop out of the fallback plan even if they liked it and go into one of the private plans.

Say they take private plan A for 2007. Then private plan A finds it is not effective for them financially to be in the plan, and they drop out. The next year, our senior citizen could be whipsawed into a third plan in 3 years. They could be over in private plan B. Then perhaps private plan B decides they can't afford to provide this coverage. They drop out, and our senior citizen, in the fourth year, is in their fourth plan. As I say, with different formularies—that is, different drugs—available to them, with different rules with respect to going to the local pharmacy to get their drugs, with different copays, with different premiums, with different deductibles, all of these changing—if that isn't chaos, I don't know what is. This is an area we must address on the floor with amendments in order to remove some of this uncertainty for seniors moving ahead.

For those of us who represent rural areas, the fact that only 2 percent of rural counties had two or more Medicare+Choice plans in August 2001 ought to tell us that our people are the most likely to be caught up in this whipsaw effect. Our people in rural areas are the most likely not to have two private drug-only plans available to them, or PPO plans or HMO plans. The reality is, they are not there now. In my State, there is virtually no coverage from those kinds of entities, almost none. Those who are suggesting that people are going to rush to this kind of business when the people who run the companies tell us very directly they are not going to—we ought to pay attention to that. We ought to listen to that. We ought to respond to it. I don't think it is going to do any of us any good to create a circumstance in which a senior we represent gets whipsawed back and forth between plans, changing premiums, changing deductibles, changing coinsurance, changing what drugs are covered and what are not.

There is one thing I have learned in dealing with seniors, especially those who are ill: They need simplicity. They need an assurance of what is covered, what isn't covered, and how it works. We should not be subjecting them to a changed plan every single year. That is not a plan that meets the needs of seniors.

I urge my colleagues to pay close attention to the debate when we begin to offer amendments to try to provide some greater certainty and stability to the plan.

I also am concerned about disappointed expectations. As I travel my State, when there is a discussion of prescription drug coverage, I find most people think that means they are going to get something similar to what Federal employees receive, or they think they are going to get something similar to what people in the military receive, or they think they are going to get something similar to what big companies provide. That is not this plan. Let's understand what this plan is and what it is not.

To provide the same coverage that we provide Federal employees would not cost the $400 billion in this plan. It would cost $800 billion. It would cost $800 billion in comparison to the $400 billion in this plan to provide the prescription drug benefit we provide Federal employees.

To provide the same level of benefit to our Nation's seniors that we provide our members in the military would cost $1.2 trillion, three times as much as available in this plan.

It is critically important that we not overpromise, that we not mislead people as to what they are getting and not getting. The fact is, there are some who I have heard say this is a 70 percent subsidy. I don't know where they get that number. That is exactly the kind of language and rhetoric that is going to lead to some very disappointed people. There is no 70 percent subsidy here. There may be for people who have extraordinarily high drug costs. I already indicated they get 90 percent of their bill paid for, over $5,800 in drug costs a year, but that is a very small percentage of the people.

It is true that very low income people get a higher percentage paid for by Medicare. But overall, we should understand, of the $1.6 trillion of drug costs for our Nation's seniors, this legislation is going to cover 23 percent of that, not 70 percent, as I have heard stated during the debate. Twenty-three percent will be paid for by Medicare.

If you look at this $400 billion legislation, $360 billion of the cost is for prescription drug payments—$360 billion. The total drug cost of our Nation's seniors is $1.6 trillion; $360 billion of $1.6 trillion is 23 percent, it is not 70 percent. So let's not be misleading people about how extensive this benefit is.

That is not to say it is not a good bill because we are limited to $400 billion. This is about as good a bill as you can write for $400 billion. But I hope we don't mislead anyone as to what it really provides.

One of the things we also need to think carefully about as we consider floor amendments is that 37 percent of retirees with employer drug coverage will lose it under the Finance Committee plan.

Why? Because the Congressional Budget Office says when employers look at this plan, some substantial number of them will drop their old coverage—the coverage they are providing. That will affect 37 percent of retirees who currently have employer drug coverage.

I think we need to take additional steps to provide incentives to those employers to keep on providing the drug coverage they provide. That is in our economic and financial interests, and it is in the interests of seniors to maintain stability in plans that they know and like.

Mr. President, I hope this information is useful to our colleagues. As I say, as a member of the Finance Committee and as ranking member of the Budget Committee, I support this legislation. I voted for it. I think it merits the support of our colleagues. I hope it can pass with resounding support here in the Chamber. I hope it will ultimately become law. We ought to do this with our eyes wide open. We ought to understand exactly what it provides and what its weaknesses are. We ought to communicate that clearly to the American people. We ought not to overpromise or misrepresent. Disappointed expectations can swamp this boat.

I am hopeful these remarks made clear what is provided and what is not and those places where we have an opportunity to improve this legislation. I think it is in all of our interests to commit our best efforts to do that over the coming days. I yield the floor.

I suggest the absence of a quorum and ask unanimous consent that the time of the quorum call be charged equally to both sides.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. BUNNING. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. CRAPO). Without objection, it is so ordered.

Mr. BUNNING. Mr. President, I rise in support of S. 1, the Prescription Drug and Medicare Improvement Act of 2003. Last week, the Finance Committee took a historical step by passing the Medicare bill out of the committee by a strong bipartisan vote of 16 to 5, thanks to the great leadership of Senators GRASSLEY and BAUCUS.

This is one of the most important bills we will consider this Congress. As a new member of the Finance Committee, I was proud to support it. It is a commonsense bill that strengthens and improves the Medicare Program by guaranteeing a prescription drug benefit for America's seniors. I hope the bipartisanship momentum that was created within the Finance Committee will continue during the Senate floor debate.

Talk is cheap. Congress has been talking about passing a drug bill for years. Now we have a golden opportunity and we must seize it. Our seniors have waited too long. It would be irresponsible to leave them hanging any longer. Under the budget that we passed, we have set aside $400 billion for a Medicare prescription drug benefit. This is a real commitment by Congress to the 40 million Americans who have relied on Medicare, many of them literally all their lives.

It has been almost four decades since Medicare was created, and it is long past time for Congress to strengthen it and to help bring it into the 21st century.

In 1965, when Medicare became law, prescription drug coverage was not included in the benefit package. Back then, it did not make any sense. Prescription drugs played a much smaller role in medical care. But because of technology and advances in health care, and much research that has been done since then, these drugs now do so much more in helping to ensure the good health of America's seniors. These medicines help seniors live longer. They help them live more active and fulfilling lives.

Medicine has changed in a way no one could have predicted back in 1965. However, Congress has failed so far to strengthen Medicare and to recognize these advances and to account for the changes in health care. We now have a chance to make up for that lost ground.

If we are going to maintain a decent Medicare Program for seniors and fulfill our promises to them, we owe it to them to do the best we can to make sure Medicare fully recognizes their needs and the advances in modern medicine.

We have all heard of the amazing advances in prescription drugs, but for many seniors these new lifesaving drugs are unaffordable. Under the bill before us today, many more of these drugs will be within reach of all seniors. This is a good bill for them, and it is a good bill for America.

Part of this legislation deserves special mention. First, the bill gives seniors a new option when it comes to getting their health care. Now under Medicare, most seniors are enrolled in traditional fee-for-service plans. That is understandable. It is what they know and it is what they are comfortable with. About 12 percent of seniors are currently enrolled in Medicare+Choice plans. These are managed care plans like HMOs.

Under this legislation, seniors will have another new option: Preferred provider organizations, or PPOs, for their health care. Outside of Medicare, many Americans have found PPOs to be a solid alternative instead of fee for service or HMOs that some patients find to be too restrictive. Wisely, the bill includes incentives to make sure that PPOs will cover both rural and urban areas, and all seniors in these areas will be eligible to enroll.

Coming from a small, rural State such as Kentucky this is especially important to me. In many rural parts of my State, seniors do not have a choice because the economics just do not work. But the chairman of the Finance Committee wisely crafted this bill to provide incentives to ensure that seniors in rural America have choices, too. If it is good for Iowa, I think it is going to be good for Kentucky.

This bill does not require seniors to move into a PPO or an HMO for a better drug benefit. This idea has been part of other plans on Capitol Hill, and I disagree with it. Instead, under this bill seniors can receive an equal drug benefit under traditional Medicare. We give seniors the choice. It is voluntary. I know many seniors, especially our older or maybe our oldest seniors, will not want to switch out of traditional fee for service. They should not be forced to do this.

My mother-in-law is very happy with what she has, and I am sure she will not change no matter what. That is fine. After promising her she would always get the care she is now receiving, it would be wrong for us to pull the rug out from under her or anybody like her.

In order to be fair to all, this legislation says the drug benefits will be equal in both traditional Medicare and managed care plans, so seniors will not be penalized for staying with traditional Medicare Programs they know and are comfortable with.

Another positive about the bill's benefits is the fact that seniors will have more of a choice to find a drug plan that best suits their needs. This is very similar to what Federal employees do when they choose their health care plans. For example, the benefit structure for plans can differ slightly and the formularies for the plans will likely be a little different one from another. It is this flexibility and choice for seniors which really helps make this bill a winner.

I am also pleased the legislation provides a strong benefit to seniors who have the hardest time affording drug coverage, those who have incomes below 160 percent of the poverty level.

All along I have argued that rich people such as Warren Buffett and Bill Gates do not need our help. We need to first focus on helping seniors who need it most and can afford it least. I am very pleased this bill does just that.

At 160 percent of poverty, an individual's annual income is $14,368 for a single person, and for a couple annual income is $19,392. Many seniors in this category and certainly those who live on less struggle every day to pay for their medicines. Some have to actually choose between food and medicine. Some skip taking doses of their medicine. These are choices that no none in the year 2003 should have to make.

For the 3 million seniors who make even less, the bill provides them with an even more generous benefit. These are our seniors for whom Congress has the largest responsibility. This bill certainly does right by them.

Finally, I am pleased the legislation provides immediate help right now to many low-income seniors. In the year 2004 they will receive $600 a year so they can better afford their prescriptions. This is an immediate benefit for those who need help the most and will help bridge the gap until 2006 when this new drug program is fully up and running.

Congress has a golden opportunity to pass a good prescription drug bill. We absolutely cannot let it slip through our fingers. Too many seniors struggle daily to pay for their prescriptions. In the past, Presidents and Congresses have promised too much, too many times, for older Americans. It is standup time. It is time to deliver. It is time to get the job done. Our seniors deserve it. America deserves it.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. SMITH. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SMITH. Mr. President, I rise today in support of the Prescription Drug and Medicare Improvement Act of 2003.

I am so pleased to be on the Senate floor today for this historic event. Within the next 2 weeks, for the first

time in our Nation's history, the Senate is going to pass a real prescription drug benefit for all seniors.

This historic time does not come a moment too soon. For years, seniors all over the country have been making hard choices—choices between filling a prescription and buying food; choices between losing their homes or buying the drugs they need to stay alive and healthy.

The prospect of providing senior citizens with access to life saving prescription drugs under Medicare for the first time is truly exciting. It is truly a historic achievement of the 108th Congress.

When I talk to senior citizens around Oregon, access to prescription drugs is the issue by far that resonates most clearly among them.

The Senate special Committee on Aging held a field hearing in Oregon last August. I was privileged to chair that hearing. We were tasked the issue of adding prescription drugs to the Medicare program. The room was packed with seniors from all around the State.

When I asked them to tell me how much they spent each month on drugs, their answers were astounding. They were astronomical.

And of course, there were the seniors who were paying for their drugs. Others made the decision not to fill prescriptions or to skip doses, cut their pills in half or try cheaper remedies.

One of our star witnesses was 76-year-old Roy Dancer, a retired educator from Beaverton, OR. He testified that many of his friends in his small retirement community have out-of-pocket expenses for prescription drugs that well exceed $5,000 per year, including one resident with no insurance whose drug costs exceeded $8,500 per year.

Mr. Dancer was an active member of his community. One of the ways he maintained his health was by taking eight prescription drugs daily. His wife, Betty, was also being kept healthy and active by using multiple medications daily for her high blood pressure, diabetes, and arthritis.

Mr. Dancer told the committee that he had once gone to Mexico to purchase prescription drugs to save money.

That is just one small snapshot of a relatively healthy couple in a relatively affluent retirement community with relatively healthy residents.

At that field hearing, the committee also heard from an Oregon geriatrician who described the irreplaceable benefits of modern prescription drugs, and the importance of patient compliance with a prescribed drug regimen to achieving the full potential benefits of contemporary medical care.

This Aging Committee field hearing was held just 2 weeks after the Senate's failed attempt to pass a prescription drug benefit last year. And let me tell you, this failure weighed heavily on me during that hearing.

We are talking about basic access to life saving medicines—many of them developed in this country—and in many cases these folks just could not afford to buy them.

It was a truly humbling experience to listen to the stories of these good people and know that we had not helped them.

I want to be able to go back to the seniors in Oregon this year and tell them what the U.S. Senate has finally done for them.

This year, I joined the Finance Committee, and we have had many, many meetings to discuss how to design a drug benefit this year that we can actually pass and get to the President's desk. And with this bill, I think we have accomplished that.

Every Senator comes to the floor with their views of what is the perfect. The question again becomes, Will our individual views of the perfect thwart the good? Truly, this bill represents a lot of good, and it certainly is a very good start.

When this bill is signed into law, no senior will again ever have to lose their home when they lose their health.

This bill provides substantial assistance to low income seniors, while making improvements to the Medicare program, all in a way that will ensure the financial viability of the Medicare program in the long term.

This bill doesn't give anyone a free ride. Every senior is asked to contribute something for this sweeping new benefit. However, low-income seniors, in particular, are protected from high drug costs under this legislation.

While everyone will pay something for their prescriptions, payments for low-income seniors are tied to their ability to pay. Very low-income seniors will pay very little for their prescriptions, while moderately low-income seniors will pay a little more.

Higher income seniors will pay a small premium to have access to a plan with moderate cost sharing, and, importantly, protection against catastrophic drug expenses. The peace of mine from this coverage alone is, for me, one of the most important provisions in this bill.

In addition to making prescription drug coverage available and affordable to all seniors, this bill updates the Medicare program to include new choices for seniors.

Making preferred provider organizations, available to seniors has enormous potential to improve care coordination and provision of preventive services for seniors.

Let me tell you why this is important.

Medicare beneficiaries with multiple chronic conditions are by far the most expensive group of seniors to care for. Their care is also the most complex, creating quality of life challenges for many seniors, their multiple health care providers, and their families.

Beneficiaries with 5 or more chronic conditions represent 20 percent of the Medicare population but account for 66 percent of the cost. These seniors to go the doctor four times as often, and fill five times more prescriptions than healthier seniors.

I believe there is an enormous potential to improve care for this rapidly growing group of seniors while keeping costs down for Medicare by coordinating their health care better.

Preferred provider organizations can help do that. And while no senior in America will have to move into a PPO, they will now have the option to do so. In my mind, that is a substantial improvement to Medicare.

For the first time in a long while, this bill also addresses one of the biggest problems in Medicare—the inequity between rural and urban America. I would like to thank Chairman GRASSLEY again for his personal commitment to this issue and for his tireless efforts on behalf of rural States such as Oregon.

In addition to correcting some of the Medicare reimbursement issues that have disadvantaged people and health care providers who live and work in rural areas, this bill contains numerous protections to ensure that rural Americans have access to the same health care choices as urban Americans and at the same cost.

These improvements were critical to win my support for this bill, and they represent just a few of the improvements in this bill over last year's bill as it was debated.

Several months ago, the Senate Budget Committee calculated that a comprehensive, responsible drug benefit that the country could also afford would cost around $400 billion. Subsequently, the Budget Committee set aside $400 billion for the addition of a prescription drug benefit in Medicare and improvements to the program.

This bill strengthens Medicare in a substantial way. It uses the $400 billion set aside for this purpose without running the program into the ground in the long term.

I know I am not alone in striving to update Medicare in such a way that the program will be there for our children who will want to participate in it.

Americans across the country are asking for our help. They cannot afford to wait another year while we search for the perfect solution. This bill represents years of careful research, debate, and compromise, and it is going to strengthen and improve Medicare for generations to come.

I look forward to working with every one of my colleagues over the next few weeks to improve this bill and to get it to the President's desk before the end of summer.

Mr. President, I thank you for the time.

Mr. President, I ask unanimous consent that the time spent in quorum calls during today's session be charged equally to both sides.

The PRESIDING OFFICER (Mr. CHAFEE). Without objection, it is so ordered.

Mr. SMITH. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. KENNEDY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. CHAFEE). Without objection, it is so ordered.

Mr. KENNEDY. I understand there is a division in the time. How much time do we have on our side?

The PRESIDING OFFICER. Sixty-five minutes.

Mr. KENNEDY. I yield myself such time as I might consume.

The history of America is that of a people always fighting for an ever more perfect union, a nation of genuine fairness and opportunity for all, and that meets the basic needs of all Americans.

We fought to create public schools, so all children can receive an education to help them succeed, and to equip them to participate fully in our society.

We have battled for civil rights, so that no one is denied opportunity because of race, gender, religion, national origin, or disability.

We fought for a fair minimum wage, so that those who work 40 hours a week, 52 weeks a year, should never live in poverty.

We created Social Security and Medicare, so that those who work their entire lives, and contribute so much to the nation, will be cared for in their golden years.

But ours is always an unfinished republic. With each generation, and in each era, we continue to perfect our democracy and to fight for progress.

And today, one of the great challenges of our time is at long last to right an injustice that has harmed millions of our fellow Americans, the fact that Medicare today does not provide a prescription drug benefit.

Many of us in the Senate have battled for such a benefit for almost a quarter of a century. In fact, Senator Strom Thurmond and I introduced the first legislation to create a prescription drug benefit in 1977. And in more recent times, Democrats have led the charge. In 1999, Senator ROCKEFELLER and I introduced key legislation to provide prescription drug coverage in Medicare. In 2002, Democrats led the way once again in offering the Graham-Miller-Kennedy Medicare prescription drug bill.

For too many years, the prospects of enacting a Medicare prescription drug benefit were jeopardized by the insistence of many Republicans and the Bush administration to destroy Medicare by forcing seniors to leave their family doctors and join HMOs and PPOs. In fact, President Bush proposed to use a prescription drug benefit as bait, telling seniors that if they wanted prescription drug coverage, they had to leave Medicare to get it. While purporting the give seniors choices within Medicare, his plan in fact gave seniors only one option, to leave the Medicare they love to get the prescription drugs they need. The only winner in this misguided policy would be the insurance industry, which stood to gain $2.5 trillion dollars from the privatization of Medicare.

Democrats and senior citizens locked arms to fight this proposal. We stood up for Medicare and its promise to provide the health care needs of seniors citizens in retirement. Senior citizens across America said it's wrong to coerce them into leaving their family doctors and joining HMOs and PPOs to get the drug benefits they need and deserve.

In recent days, the voices of America's 35 million senior citizens were finally heard. Last week, a bipartisan group of Senators rejected the President's backwards priorities, and President Bush retreated from his insistence on privatizing Medicare. Instead of holding the needs of seniors hostage to an ideological agenda, Republicans' willingness to put aside ideology and work with Democrats to create a prescription drug benefit now paves the way for the largest expansion of Medicare in its 37-year history. After many years of battling for a Medicare prescription drug benefit, we now face the very real prospect that Congress can pass, and the President will sign, a bill that provides the prescription drug benefit within conventional Medicare.

In fact, if you think Medicare should be privatized, then you should oppose this bill.

This promising moment comes at a time of crisis for millions of our senior citizens. Too many elderly citizens choose between food on the table and the medicine they need. Too many elderly Americans are taking only half the drugs their doctor prescribes, or none at all, because they cannot afford them. Today, the average senior citizen has an income of around $15,000, and prescription drug bills of $2,300. That is the average, and many senior citizens incur drug costs in the thousands of dollars each year.

Senior citizens are faced with a deadly double whammy. Prescription drug costs are out of control, and private insurance coverage is drying up. Last year, prescription drug costs soared by a whopping 14 percent. They have shot up at double-digit rates in each of the last 5 years. Whether we are talking about employee retirement plans, Medigap coverage, or Medicare HMOs, prescription drug coverage is skyrocketing in cost, and becoming more and more out of reach for the elderly.

This chart reflects the rise in costs as compared to what our seniors are receiving in their Social Security COLA increase, going from 1998 where there was a 10 percent increase in the cost of prescription drugs but seniors were getting only 2.1 percent. In 1999, it was 19.7 percent and the increase in the cost of living was at 1.3 percent. Then we go throughout 2000, 2001, 2002, and today in 2003 it is expected to go up to 13 percent with seniors receiving a very modest 1.4 percent.

When we are talking about what is happening to the quality of life of our seniors, we are talking about these absolutely vital, indispensable medications, prescription drugs, which they need and which are costly. The fact is, so many of our seniors are on fixed incomes that with very modest increases in the cost of living they are constantly being squeezed, and this is putting the kind of pressure on them and on their lives and on their families which has caused such extraordinary pain, suffering, and anguish among the seniors; and not only among the seniors but among their families as well.

The costs are one of the dramatic aspects of the whole prescription drug issue, and we are going to make a downpayment hopefully with the acceptance of the legislation that came out of our committee. The initial McCain-Schumer legislation which now is supported unanimously from our committee will help to move generic drugs on to the market more quickly and be available to our seniors under this program.

It used to be that the only seniors with reliable, adequate, affordable coverage were the very poor on Medicaid, but even that benefit is eroding. Today, because of the State fiscal crisis created by the recession and the let-them-eat-cake attitude of the Republican party, even the poorest of the poor can no longer count on protection. States are now facing the largest budget deficits in half a century, an estimated $26 billion this year, and $70 billion next year.

This chart is a pretty good reflection of the situation of our seniors on the issue of affordable, reliable and quality drug coverage. Thirteen million have absolutely no coverage; 10 million have employer-sponsored coverage; 5 million are under Medicare; 2 million are under Medigap; 3 million are under Medicaid and a small amount on other public coverage.

It used to be said of this group, it was the one group listed here that had dependable, reliable, certain drug coverage for those under Medicaid, but that is no longer true. We are seeing the numbers covered under Medicaid going down every year. With the States now facing very sizable deficits, they are cutting back on the Medicaid and the coverage.

The result is States are cutting back on the prescription drug coverage for those least able to pay. Thirty-nine States expect to cut their Medicaid drug benefit this year. In my home State of Massachusetts, 80,000 senior citizens were about to lose their prescription drug coverage under the same senior Advantage Program on July 1. Emergency action by the State legislature solved the problem but only after making substantial reductions in the coverage.

Ten million of the elderly enjoy high-quality, affordable retirement coverage through a former employer, but retiree coverage is plummeting, too. In just 8

years, from 1994 to 2002, the number of firms offering retiree coverage fell by a massive 40 percent. The employer-sponsored column on this chart shows 10 million employer sponsored retirees.

We have 13 million with no coverage, 10 million with the employer sponsored, and we saw a gradual reduction for the poorest of our seniors. So let's see what is happening now. The firms offering retiree health benefits have dropped 40 percent from 1994 to 2002. In 1994, 40 percent of the firms offered retiree health benefits. Go back to 1988; it was about 85 percent; in 1994, it was 40 percent; in 2002, it was just over 20 to 22 percent. So we are seeing that availability constantly squeezed.

Medicare HMOs are also drastically cutting back. Since 1999, more than 2.5 million Medicare beneficiaries have been dropped by their Medicare HMOs. Of the HMOs that remain in the program, more than 70 percent limit drug coverage to a meager $500 a year or less and half only pay for generic drugs.

I have another chart showing groups of seniors. We talked about the employer sponsored seniors and the pressure they are under; we talk of the pressure under the Medicaid. Let's look at those 5 million under the Medicaid HMO and see what has happened to them: 2.4 million have been dropped, and of the remaining, take a look at what has happened. The Medicare HMOs are reducing the level of drug coverage. Sure, some provide it, but 86 percent limited the coverage to less than $1,000 in 2003; 70 percent imposed caps of less than $500. So although they are providing, if the average expenditure of a senior is $2,300 and HMOs are limiting it to less than $3,500, it is an empty promise.

We have those with no coverage. We have those in the employer retirement programs who are seeing reductions; we have the HMOs seeing reduced coverage. We have seen in the Medicaid where there has been reduced coverage as well. We also see that Medigap plans that offer drug coverage are priced out of reach for most seniors, and the coverage offered by these plans is severely limited.

Thirteen million beneficiaries, as I mentioned, have no prescription drug coverage at all. Only half of all senior citizens have coverage throughout the year. It is time to mend the broken promise of Medicare. It is time to provide every senior citizen in this great country of ours with solid, reliable, comprehensive prescription drug coverage.

As we enter this debate, our great challenge is fairness for all senior citizens who need Medicare's help to afford the prescription drugs they need. The resources within this Republican budget are limited. The Republican budget provides only enough funding to cover about a quarter of the needs of America's senior citizens over the next decade. They are going to be spending $1.8 trillion. This is $400 million. They are spending $1.8 trillion, and this is $400 million, 22 percent. There will be large gaps.

It is very important to remember this is a downpayment. Those who are supporting this program are strongly committed to building on this program. It is a downpayment. We are going to come back again and again and again to make sure we are going to meet the challenges provided by this bill and out there across this country we recognize what our seniors are facing. We must ensure that the resources are available to be used equitably.

As I mentioned, this bill is a downpayment on our commitment as Democrats to provide for the needs of our senior citizens. We will do everything we can to increase the resources available to provide an ample prescription drug benefit. If we do not succeed today, we will battle the Republican budget tomorrow, next month, next year, carry this issue into the next election, if necessary, until we have in place a White House and Congress that support Medicare and give the prescription drug benefit the resources it deserves. However, we must get started.

This bill does much that is good. It provides a low-income benefit that assures 40 percent of all seniors that they can get help with drug expenses with minimum premiums and copays. It saves the average senior with average drug costs approximately $600 a year—not as much as we should be providing but a good downpayment toward a contract with the seniors.

This next chart is for a senior with an average income of $15,000. They average $2,300 in prescription drugs. This is how the program works. For $420 in premium, they will pay $1,298 in cost sharing, and they get a benefit of $604, not as much as we would like to have, but nonetheless that $604 for an average income senior citizen is an important resource and assistance to them.

The next chart shows the same senior citizen with $15,000 of income. Say they have $10,000—we have taken the average income and the average amount of expenditure for prescription drugs, and now we have the average income of $15,000—this senior has $10,000 for prescription drugs. That is a lot of money, but there are certain pills, for example, dealing with treatment of cancer, that are $68 each. These expenditures can be run up relatively easily, and they are run up by many of our seniors. This is $10,000; they would pay in $4,500 and they would receive $5,462 in savings under this bill. This is a not insignificant amount of savings.

The next chart shows families with lower incomes. We are going from $9,000 to $12,000, to $13,000. This reflects the current monthly drug costs, so we are talking $2,300 a year at $190 a month for the average. This is the way this bill treats them. The monthly costs for a senior with a $9,000 income would be $5, and they would save $185. If there was a $12,000 income, and they still had to pay the $190, which again is the average, their monthly cost would be $10, and they would save $180. If the income was $13,500 and they spent the $190, their monthly cost would be $23, and they would save $168.

So the help, the assistance for the 40 percent of our seniors at the lower end of the income is very substantial, as it should be. We have seen where, even for the average income for the senior, it still provides about $600. For those with an average income for seniors, with higher amounts of prescription drug expenses, it provides a very important and substantial relief for them.

In addition to this—this is one of the most appealing aspects of this program—this bill offers immediate relief for seniors. We are talking about next January. Five million low-income seniors will receive a $600 prescription drug credit card on January 1, 2004. The most they will pay for it is $25. But for those of limited income, they will get that free, and they will have the first $600 prior to the time the program goes into effect, which will be in 2006. This will be available to them in January 2004. All seniors can receive savings through the drug discount card. This is enormously important. If a senior doesn't use the whole $600, they can carry that over for another year.

Help is on the way, immediately, for 5 million seniors starting in January of next year. That, I believe, is enormously important and positive news for many seniors.

While this bill does much that is good, it still has serious gaps and omissions. It will still leave many elderly suffering from severe financial strains as they try to purchase the prescription drugs they need. It doesn't provide the retiree health plans with the fair treatment they deserve to assure they can continue to meet the needs of retired workers. It could be improved by changes to ensure the coverage provided every senior citizen will be as stable and reliable as possible. During the course of this debate, Democrats and Republicans in the Senate will try to address these needs. If we are unsuccessful, we will continue to fight over the years ahead to fill in the gaps in this program.

At bottom, the issue of providing adequate prescription coverage for seniors is a question of priorities. For the administration and for too many Republicans in Congress, tax cuts for billionaires are more important than health care for senior citizens. But Senator GRASSLEY, and I see him on the floor here today, and Senator BAUCUS and the other members of the Finance Committee deserve enormous credit for the excellent job they have done, designing a benefit within a $400 billion straitjacket imposed by the budget resolution.

I also pay tribute to the majority leader, Senator FRIST, for his strong leadership, assisting the Finance Committee, contributing to the shaping of this program which I think is commendable. It needs work but it is a very important, significant, and positive start.

Because this program covers only about a quarter of the elderly's drug expenditures, it still leaves too many elderly—those with incomes below 160 percent of poverty—with unaffordable costs. Forty percent, those with incomes below 160 percent of poverty, will have comprehensive, affordable coverage through this program or through Medicaid. This is a tremendous achievement. But others, particularly the middle class with moderate incomes and high drug expenses, still face high drug costs. The benefits under this bill—a $275 deductible, 50 percent cost-sharing, an out-of-pocket limit of $3,700 with continued copayment obligations after the limit is reached, are far less generous than those enjoyed by most younger Americans, even though the elderly's need for prescription drugs is much greater.

We have talked about what they call the doughnut hole, where there is very comprehensive coverage for those at the lower end and very substantial help for those at the higher end, and less help and assistance for those in the middle. That will be one of the issues which we will have a chance to address here on the floor, to try to see if we can't provide some additional help to those who will not be benefitted as extensively as those other two groups. That will be in the form of amendments that will be introduced and hopefully supported.

Also, I mentioned the serious issues that work because of the interaction of this program in terms of retiree benefits that can potentially threaten retirees, and is an issue that must and should be addressed. I am hopeful it will be before final passage.

A final area where this bill could benefit from improvements is in the rules and regulations established for the private insurance plans that are the vehicle for delivering prescription drug benefits to senior citizens and the disabled, and for the fallback plans that will deliver the benefit when there are not two insurance plans meeting Government standards in each region of the country. The sponsors of this bill have done much to assure that individuals who enroll in private plans will pay a reasonable premium, and that there will always be coverage available in every area of the country. But more can be done and should be done to assure that premiums are reliable and affordable everywhere and that senior citizens do not have to change plans frequently because of instability in the market.

Many Democrats were concerned that last year's Republican bill could prove unworkable because private insurance plans might not be willing to provide the drug benefit. The concern was especially strong in rural areas, where HMOs and PPOs have been unwilling or unable to provide services. Under the compromise plan, there will be a government drug plan available in any place where there are not at least two private drug plans meeting Medicare standards available. To increase stability of choices for senior citizens, private drug plans must remain available in any region they choose to enter for at least 2 years. Thus, the bill guarantees that every senior citizen, no matter where they live, will be able to receive the benefits provided in the bill.

The Republican bill last year relied solely on competition to keep drug plan premiums reasonable for senor citizens, leaving senior citizens vulnerable to exorbitant charges and profiteering if competition was ineffective. This year's bill establishes tight regulatory criteria to assure that plan premiums are fair. It uses the same rules that govern the Federal Employee Health Benefits program.

Specifically, the bill states that a plan cannot be approved to participate in the drug program unless its premiums are ''reasonably and equitably reflect the cost of benefits'' provided under the plan. In the FEHBP program this requirement has been interpreted to allow health plans a maximum markup of one percent over costs.

Democrats have been concerned that private drug-only plans might deny beneficiaries access to off-formulary drugs in order to reduce costs and maximize profits. Last year's Republican bill contained no independent appeal rights and did not require that beneficiaries receive off-formulary drugs at the preferred drug rate even if an internal appeal were successful. The compromise program requires the plans to cover at least two drugs in each therapeutic class, establishes a strong independent appeal process, and provides that off-formulary drugs can be obtained at the preferred drug rate if an appeal is successful.

This week the Senate has an opportunity to make the bill better. But we must also guard against it becoming worse. This bill provides fair treatment and the opportunity for new choices for senior citizens who want to stay in Medicare as well as for those who might consider a private insurance alternative.

The President's plan, by contrast, sought to stack the deck against Medicare—and against senor citizens. Instead of the trustee of the Medicare program, his plan would have made the Government little more than a shill for HMOs and the insurance industry. Seniors would have been poorer, their medical options would have been constrained, their ability to choose their own doctors would have been compromised, and all so that wealthy HMOs and insurance companies can become even wealthier.

If all senior citizens can be forced out of Medicare and into HMO and private insurance, the revenues of the insurance industry will increase by more than $2.5 trillion over the next decade. Same on the insurance industry for supporting this plan, and shame on the administration for putting the interests of wealthy and powerful political supporters above the interests of the senior citizens who have built this great country.

The bill before the Senate says no to this outrageous scheme. But I anticipate that amendments will be offered during the course of this debate to tilt the scales once again against senior citizens and for private insurers. It is unlikely that any Member of the Senate will publicly demand, as the President did, that senior citizens give up their choice of doctors in order to get prescription drugs. But there are more subtle ways of unraveling Medicare. Amendments may be offered to uncap Federal payments to private insurers, so that they have an open tap to the Federal treasury, even if their services cost more than those same services provided by Medicare. We need help for senior citizens, not corporate welfare for insurance companies that seek to undermine Medicare.

There are other ideas that could destroy our bipartisan compromise. The President says that he has embraced the bipartisan Senate compromise. But some are considering implementing a vast experiment on senior citizens all over this country. This experiment—called ''premium support''—is yet another attempt to force senior citizens into HMOs and other private insurance plans. It is more subtle but just as unacceptable as the President's original proposal. It could dramatically raise Medicare premiums and victimize the oldest and sickest of the Medicare population. It is a poison pill that could kill the prospects for reform and destroy all the progress that has been made in the Senate.

I am also gravely concerned by other proposals that would establish, for the first time, a means test for Medicare benefits.

One of the reasons that Medicare is such a popular and successful program is that all individuals, rich and poor alike, contribute, and all benefit. Senior citizens want Medicare, not welfare. And tying catastrophic benefits to a person's income is the camel's nose under the tent that could lead to the dismantling of Medicare and its replacement with welfare.

As this debate progresses, there will be a vast array of facts and figures discussed in this chamber. Many of the issues will be discussed in language that will seem technical and arcane to the average American. All of us must strive to remember why this debate is important and what it is really about.

The typical Medicare enrollee is a seventy-five year old widow, living alone. Her total income is just $11,300 a year. She has at least one chronic condition and suffers from arthritis. In her younger years, she and her husband worked hard. They raised a family. They stood by this country through economic hard times, the Second World War, the Korean War, and the Cold War. They sacrificed to protect and build a better country—not just for their children but for all of us. Now it

is time for us to fulfill our promise to her. It is time to assure her the affordable health care she deserves. It is time to pass a prescription drug benefit under Medicare.

I suggest the absence of a quorum, and I ask unanimous consent that the time be equally charged to both sides.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. DODD. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DODD. Mr. President, what is the business before the Senate?

The PRESIDING OFFICER. The bill, S. 1.

Mr. DODD. I thank the Presiding Officer.

Mr. President, yesterday we began what can truly be expected to be an historic effort to transform the Medicare Program in this country, an effort, if it is successful in these coming days, that would provide for the most sweeping changes to that program since its inception in 1965.

We began debate this week on the need for coverage of prescription medicines under the Federal Medicare Program. While it is a debate that is sure to be spirited in the coming days, it is my hope the debate will, in the end, result in a significant move forward that will strengthen the Medicare Program for its 41 million beneficiaries and for the millions of future beneficiaries who will depend on this critically important program for their health and their well-being.

Over the past month, I have had the opportunity to convene a series of forums on senior health care in my home State of Connecticut in an attempt to frame the scope of this debate. At these forums, I heard from many constituents on many matters regarding their health care, but the present lack of coverage for prescription drugs under the Medicare Program was far and away—without even a close second—the most important question that was raised to me by literally dozens and dozens of seniors in my State.

I would guess in similar forums being held in other States around the country by our colleagues they have encountered virtually the same reaction as did I with my seniors in Connecticut: When are we going to get a prescription drug benefit? When are we going to get it under Medicare? And will it be meaningful enough to make a difference in our lives? Over and over and over again, in all parts of my State, this was the call that I received from my constituents.

At these forums, I heard from seniors who literally could not afford to fill prescriptions called for by their doctors. I heard from elderly Medicare beneficiaries forced to choose between purchasing groceries or filling their drug prescriptions. I heard from seniors who were forced to skip dosages of their medicines in an attempt to stretch their limited supplies of needed medicines. And I heard from Medicare beneficiaries requiring more than 10 prescribed medicines a day unable to afford to fill even half of those needed prescriptions.

Clearly, what I heard from hundreds of Connecticut's more than 500,000 Medicare beneficiaries—in a State, I might add, that has 3½ million people—is their grave concern over the present lack of a prescription drug benefit under the Medicare Program.

Our goal over the next 2 weeks is very clear: to ensure that all Medicare beneficiaries have access to their needed prescribed medicines. To achieve anything less in this debate would be an abdication of our responsibility to ensure that Federal programs correspond with the times in which we live.

The simple fact is that pharmaceuticals have and will continue to better the lives of millions of Americans. When the Medicare Program was first enacted in 1965, few could even begin to imagine the great strides we have realized in health care as a result of the development and widespread dissemination of pharmaceutical medicines. However, the present lack of a prescription drug benefit under the Medicare Program fails to reflect these great gains that have been made, leaving more than half of all Medicare beneficiaries without any coverage for their needed medicines. This is unacceptable, and it must be remedied.

For this reason, I am heartened that it appears that today, for the very first time—for the very first time since we began discussion of this subject matter—we are on the cusp of passing in the Senate comprehensive Medicare reforms that will, at long last, add a prescription drug benefit to the Medicare Program.

I am particularly pleased the measure reported by the Senate Finance Committee last week, and that is before us this afternoon, represents a very significant departure from previous plans supported by the administration that would have required Medicare beneficiaries to leave the traditional fee-for-service Medicare Program in order to receive coverage for their prescribed medicines. Such a move would have been unconscionable, as 89 percent of all Medicare beneficiaries today are in the traditional program.

To force those beneficiaries to have to leave their present system of coverage, and most likely the doctor they have come to know and trust, would not only create great disruption, but it would also, for the first time since the program's inception, create a tiered benefit system under Medicare that would more greatly reward those who choose to join a private preferred provider organization or health maintenance organization over those who wanted to stay in the traditional Medicare Program.

That is what the administration was originally advocating. That is what many, unfortunately, in the other body, the House of Representatives, are still pursuing and still advocating. So I hope, as a result of the change we have seen in the last week, this breakthrough will make a huge difference in the lives of Medicare beneficiaries who want to retain the ability to stay under the traditional Medicare Program if they so choose.

And so while I am pleased the bill before us soundly rejects a tiered benefit system—and I commend the distinguished Senator from Iowa, the chairman of the committee, and the distinguished Senator from Montana, for rejecting the idea of a tiered benefit system, I am deeply concerned that the plan presently taking shape, as I mentioned, in the other body, the House, appears to rely on such a flawed plan. And until we have resolved the matters between these two bodies, this fundamental difference will still be out there and need to be addressed.

President Bush, just last week, visited my home State of Connecticut and called on Congress to pass a prescription drug benefit before July 4th. For my part, I call on the President not to sign any Medicare reform measure that would force seniors to join private plans in order to receive a more generous prescription drug benefit. Such a measure would signal an end to the Medicare Program as we know it and should be rejected out of hand. In fact, I would hope the President would say, categorically, that while he wants Congress to pass a bill before July 4th—he must say, with equal strength, that he will not sign a bill that denies people under traditional Medicare the opportunity to have an adequate prescription drug benefit or forces them to have to make a choice between staying in traditional Medicare and getting no prescription drug benefit or going to a private plan where they can get that prescription drug benefit but having to give up traditional Medicare as the price. The President needs to state that he will reject any proposal on his desk that incorporates that idea.

The bill before us, S. 1, the Prescription Drug and Medicare Improvement Act of 2003, represents a strong step forward on this issue. However, no bill is perfect, and S. 1 clearly leaves much room for improvement. In the coming weeks, I plan to work with my colleagues to specifically address concerns over the present bill's lack of adequate provisions to ensure that those companies presently providing their retirees prescription drug coverage receive adequate Federal support for their laudable efforts. Any measure that we enact should be crafted so as to support, not supplant, the valuable efforts of employers already providing prescription drug coverage for their retirees.

Additionally, I remain concerned that the gap in coverage in the present

bill—the so-called donut hole—will leave many Medicare beneficiaries facing high prescription drug costs with no assistance at the very time when it may be needed most. These may be the people who are the most sick, under the most dire medical circumstances. And if they were to reach that threshold of approximately $4,500 in prescription drug costs, they will have to maintain paying the premiums without receiving any benefit until they reach the upper limit of the gap, approximately $5,800 in drug costs. This gap in coverage could provide a huge hardship on literally hundreds of thousands of Medicare beneficiaries. I hope we are going to be able to close the so-called donut hole, especially for those in the lower income category who can least afford any gap in their coverage.

I am also concerned that S. 1 fails to adequately protect Medicare beneficiaries from the very understandable confusion and uncertainty that may surround these beneficiaries just as they begin to navigate the intricacies of a brand new program. Specifically, I am worried that, if enacted, the underlying bill would require Medicare beneficiaries choosing a prescription drug plan to stay with that plan for a minimum of 1 year. With the enactment of such broad and sweeping changes to Medicare as S. 1 would provide, I am fearful that many Medicare beneficiaries will face great uncertainty trying to find the best plan to meet their particular medical needs.

I believe we can greatly relieve this uncertainty by allowing those initially choosing prescription drug plans for the first time the opportunity to move from one plan to another as they determine what each plan will specifically offer and which plan best fits their own needs. We ought to give our senior citizens that opportunity. All Medicare beneficiaries are not the same merely because they have reached the same age. They are under very different circumstances with very different medical needs. We ought to show them the dignity and respect they deserve as an older generation to give them the ability to choose the plan that serves their needs best and not force them to have to make decisions that may do them great harm.

In the coming weeks I will offer several amendments to the legislation that will address these very specific issues and possibly other ones as well.

On July 30, 1965, President Lyndon Baines Johnson traveled to the Truman Library in Independence, MO, to sign the Medicare Program into law. In attendance on that day was the former President of the United States, Harry S. Truman, 81 years of age at the time. On that day, President Johnson remarked:

> No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they so carefully put away over a lifetime so that they might enjoy dignity in their latter years.

Almost 38 years later, we face a similar struggle of ensuring seniors access to modern medicine, this time in the form of prescribed medicines.

So it is with a great sense of hope that I join the debate this afternoon. Medicare's nearly 41 million beneficiaries clearly need assistance in affording their needed medicines. Our effort over the next 2 weeks will greatly determine to what extent we assist in that effort.

Clearly, a great opportunity is presently before us. I look forward to working with all of my colleagues on both sides of the aisle, Republicans and Democrats, to ensure that we seize this opportunity. It may not come again. While the bill before us may be less than perfect and the resources we are limited to may not be as adequate as we would like, we have an opportunity over the next couple of weeks to take the legislation presented to us by the Finance Committee, to work on that legislation and hopefully improve it in several of the areas I have mentioned.

What greater gift could we give, 38 years after Medicare's creation, to retirees and future generations of retirees than to grant them access to this wave of new medicines and prescription drugs, that cannot only extend life but can substantially improve the quality of life for people, which will give them the opportunity to enjoy years of retirement with their children and grandchildren and friends. Surely these wonderful miracle drugs ought not to become the exclusive domain of only those who can afford to buy them.

Mr. President, I do not want to have to face constituents in my State ever again who will report that they had to make a choice between putting food in their mouths or medicines that they need; that they had to choose between the medicines they need because they can't afford all of them that the doctors have prescribed, or that they reject altogether the medicines that they have been prescribed because they can't afford them. We can't do everything for everyone, but it seems to me providing a meaningful prescription drug benefit that will really serve the underprivileged in our society, particularly those age 65 and above, is something this Congress ought not to fail to do in its responsibilities.

I look forward to the debate. I look forward, more than anything else, to voting for a package in the end that will do that which most of us would like to see accomplished and seeing to it that the elderly will receive the full promise given to them back in 1965 that a Medicare Program is going to be there for them, and this time we are going to include in the program coverage for needed prescribed medicines.

I commend those who have moved so diligently and worked so hard to bring us to this very optimistic moment. I am hopeful in the coming days we can complete the job by adding some improvements here and presenting a bill to the American public which they will applaud if we correctly do our job.

I suggest the absence of a quorum and ask unanimous consent that time thereunder be equally divided.

The PRESIDING OFFICER (Mrs. DOLE). That has been provided.

The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mrs. LINCOLN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

CHILD CARE TAX CREDIT

Mrs. LINCOLN. Madam President, I am rising today to encourage my colleagues. I have gotten an understanding that the Republican leadership will be meeting in the morning to talk about the conference with the House on the opportunity we have to provide 12 million children in this country some help through the tax relief package that was passed in the Senate.

I also thank my Senate colleagues for, in a resounding way, reaching out to this country and to those 12 million children, as well as their working families, and saying we do believe it is important that the tax relief package we provide be balanced both in its fiscal responsibility and in its ability to reach out to all working families in this Nation and give them the relief so that they, too, will have the opportunity to be able to participate in stimulating the economy of the country. After all, that is what we are really looking for, stimulating the economy and making sure we are strengthening our Nation. I think there is no better place to go than to the working American families.

So I encourage my colleagues today, as I come to the floor not to ask immediately but to request of the leadership, to really thoughtfully put together what it is we need to do in order to expedite moving to conference on this issue. I also plead with the President that his efforts and opportunities will certainly weigh in with the Members of the House, encouraging them to move forward. They have already voted in the House in a motion to instruct the conferees to the Senate position. This is something we can do, and do it quickly and in a very fiscally responsible manner by paying for it. But we can do something now that is going to help working families in the next several months.

It is critical, as we move forward with the previous tax package passed, to provide relief to all Americans across this great land by July 1, and that we, too, recognize not only those precious 12 million children who are out there, but the working families they are a part of, recognizing that these families are preparing in the late summer to get their children ready to go back to school. They certainly could use those resources in multitudes of ways—bringing their families together, preparing their children for the school year. We desperately want to make sure that happens.

I encourage our Republican leadership to come together to visit on moving forward in the conference, recognizing that we have a tremendous responsibility not only to the economy of this Nation, particularly in strengthening our country, but, more importantly, to the future of the country.

When you look at those who will be the future leaders of the workforce, the individuals who will be there to continue the great legacy of this land—the children of our country—we must give those working families the opportunity to take advantage of the same kind of tax relief that other families are going to be getting; they, too, have to take that opportunity to reinvest in this great country and, more importantly, in their families and their children.

So I encourage my colleagues, as well as the leadership on the other side, to make sure that in the morning they will meet in a wholehearted fashion looking for the opportunity we have before us to be fair and balanced for the multitudes of children and working families across this country.

I, too, encourage the President to weigh in on this issue. He has a tremendous opportunity to make a difference, and I hope he will choose to do so.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. INHOFE. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. INHOFE. Madam President, I am very concerned because what I see coming at us right now is a very fast train. And that train is a giant giveaway entitlement program. We might be in a position to do something about now, but if we wait, we will not be able to do anything about it.

Medicare already accounts for roughly 12 percent of the Federal spending and will only grow as more and more baby boomers retire. When Medicare was proposed in 1965—and I am one of the few people around old enough to remember that—I can recall the estimate of Medicare Part A that would cost $2.9 billion in 1970. This was 1965. The actual expenditures in 1970 were $5.3 billion, roughly twice what they were estimating back in 1965. The estimate for 1980 was $5.5 billion. This is Medicare now. The actual expenditures that year totaled $25.6 billion. That is five times the estimated amount.

The predicted expenditures for 1990 were $9.1 billion, but the actual expenses totaled $67 billion, nearly seven times the estimated amount. Currently, 76 percent of the Medicare beneficiaries already have some form of drug coverage.

We have talked about the fact that something that is not broken does not need to be fixed. When we start looking at establishing an entitlement program today and go by the Medicare model, this is something that none of our kids and grandkids are going to be able to afford.

So if we keep in mind that 67 percent of the Medicare beneficiaries already have some form of drug coverage—much of it is better than the proposal on the table now—many of these individuals could lose this coverage if a prescription drug benefit is added to Medicare.

CBO estimates that 37 percent of the beneficiaries with employer-based prescription drug coverage would lose that coverage. This accounts for 11 percent of the total Medicare population.

Many pharmaceutical companies already offer programs that give low-income seniors their prescription drugs for free or for reduced prices. If this bill is passes in this form, the companies may eliminate these programs, forcing more people into the Medicare rolls.

One might say, well, we can legislate this and not allow them to do that. That solution is not going to work. That would be an attempt to micromanage the private sector, and that would not work. I do not think there is any Member of this Senate who, if they owned a company that was giving away free programs, then the Government came along and offered something, that they would continue that practice. That is exactly what would happen.

The need to get this legislation to the floor and passed by the end of June, along with the need for bipartisan support, has led to a series of compromises that have resulted in a hodgepodge of a bill. There are elements of this bill that are not only bad policy but will have a detrimental effect on the system as a whole; for instance, the extension of instant Medicaid benefits to illegal aliens, placing an additional burden on Medicaid; loss of employer-based benefits, thus expanding an already large entitlement program.

According to an editorial in the Wall Street Journal yesterday, Monday, seniors already own 60 percent of all the wealth of the country and their worth is only increasing. We cannot continue to finance entitlement programs on the backs of current American workers, which is what this bill does.

The bill is not means tested. We are giving multimillionaires, even billionaires, the same benefit offered to seniors on fixed incomes. In other words, the Bill Gateses and Warren Buffetts would get the same benefit as a retired schoolteacher.

There is a need for Medicare reform to ensure the solvency and stability of the program. However, the current version of this bill does not meet those needs.

I look forward to working with my colleagues to improve this legislation through amendments designed to encourage employers to retain the drug coverage they currently offer, to allow seniors to take advantage of private plans and better options, and to keep the costs low.

I will read a little bit of the editorial I read on the plane coming back to Washington. It says:

The bill that passed the Senate Finance Committee last week would cover just 50 percent of the drug expenses between $276 and $4,500 annually, then zero up to $5,800, and 90 percent thereafter. That's nowhere near as good as many seniors currently have with employer-sponsored coverage. Most employers will drop or scale back that coverage once they realize that the feds are willing to pick up part of their tab.

That is human nature. That is what we are talking about.

The Congressional Budget Office estimates that 37 percent of those with employer coverage could lose it.

I ask unanimous consent that the entire article be printed in the RECORD at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. INHOFE. We want something to happen. We know there are some plans out there that have been offered that take into consideration that we do not want one Government program that is going to end up being an entitlement program. If it ends up the way it is today, I am going to serve notice right now that after every effort we can make to pass amendments, if they do not work and we end up with what we have today, I am going to be opposing this plan, and hopefully there will be several others who will do the same thing.

EXHIBIT 1

MEDICARE DRUG FOLLY

Runaway trains are hard to stop, but someone has to try and derail the bipartisan folly now moving ahead under the guise of Medicare ''reform.'' Permit us to put a few facts on the table, in the (probably fanciful) hope that somebody in the White House still cares more about the long-run policy than the short-term politics.

Let's start with the amusing irony that the supporters of this giant new prescription drug benefit are many of the same folks who were only recently moaning that a $350 billion tax cut would break the budget. That tax cut will at least help the economy grow. But the new Medicare entitlement is nothing more than a wealth transfer (from younger workers to retirees) estimated to cost $400 billion over 10 years, and everyone knows even that is understated.

The real pig in the Medicare python doesn't hit until the Baby Boomers retire. Social Security and Medicare Trustee Tom Saving told us last week that the ''present value'' of the Senate plan—the value of the entire future obligation in today's dollars—is something like two-thirds the size of the current $3.8 trillion in debt held by the public.

Bill Clinton's Medicare administrator, Nancy-Ann DeParle, correctly calls it the ''biggest expansion of government health benefits since the Great Society.'' She's delighted to see it, but for the rest of us it is a recipe for tax increases as far as the eye can see.

And these estimates are before Democrats ''improve'' the benefit, as they are already agitating to do. That's because the dirty secret of this bipartisan lovefest is that the proposed drug benefit isn't all that great.

The bill that passed the Senate Finance Committee last week would cover just 50% of drug expenses between $276 and $4,500 annually, then zero up to $5,800, and 90% thereafter.

That's nowhere near as good as many seniors currently have with employer-sponsored coverage. Most employers will drop or scale back that coverage once they realize that the feds are willing to pick up part of their tab. The Congressional Budget Office estimates that 37% of those with employer coverage could lose it.

A Goldman Sachs analyst last week called this bill the ''automaker enrichment act,'' saying companies like Ford and GM would see a 15% reduction in their annual drug spending and a huge decrease in unfunded liabilities. So unborn taxpayers will soon have to pick up the tab for sweetheart labor deals negotiated by carmakers and their unions a generation or two ago.

Understood in these terms, a universal drug benefit is neither necessary nor morally justifiable. Some 76% of seniors already have some prescription drug coverage, as the nearby chart shows. The average Medicare beneficiary spends an affordable $999 a year out of pocket on prescription drugs, and less than 5% have out of pocket expenses over $4,000.

Seniors already own 60% of all the wealth in this country, and are getting richer. A report in Health Affairs estimates that by 2030 about half will have incomes of $40,000 and about 60% will have assets of $200,000 or more. We're all for a prosperous old age, but it is hardly a step toward social justice for comfortable retirees to be further subsidized by working taxpayers with mortgages and kids. The problem of genuinely poor seniors can be handled with a drug discount card or a means-tested subsidy.

We understand, of course, that these facts are unlikely to interfere with the political calculus driving this giant step toward Canadian health care. The Democrats want to expand the welfare state, while Republicans have convinced themselves that they'll get credit with seniors and be able to take health care off the table for 2004.

The Republicans are fooling themselves in the long run, and perhaps even about next year. Republicans can never win an entitlement bidding war. They will spend the rest of their public lives sounding like Scrooge for not expanding benefits, or raising taxes on their own voters to pay for the subsidies, or imposing price controls on drug makers that will stifle innovation. This is how parties of the right became me-too socialists in Europe.

The sheepish support for this from the likes of otherwise conservative Senators Rick Santorum and Mitch McConnell gives the game away. They're playing loyal spinners, but their heart doesn't seem to be in it. They're going along for the ride with a Republican White House that seems to have forgotten that it has an obligation to more than its own re-election.

Mr. INHOFE. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. HATCH. Madam President, I ask unanimous consent the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HATCH. Madam President, I would like to take this opportunity to discuss a particular interest of mine: how the ''Prescription Drug and Medicare Improvement Act of 2003'' will protect beneficiaries in rural areas.

As we worked to develop S. 1, members of the committee were especially attuned to the concerns expressed by some that private entities will be unwilling—or perhaps unable—to provide services to Medicare beneficiaries living in rural communities. That is why we included a number of safeguards to make certain that rural elderly and disabled patients have access to the Medicare improvements made in S. 1.

I cannot overstate how particularly important this is for my home state of Utah, since most of the 29 counties and 82,144 square miles in Utah are rural.

According to the 2000 Census, Utah's population density was only 27.2 persons per square mile, roughly one third of the national average of 79.6 persons per square mile.

So I am very interested in seeing to it that Medicare beneficiaries in rural areas—whether they are in Utah or for that matter in the State of New York, I want to make sure these beneficiaries get a fair shake.

There is no question that the Medicare beneficiaries who live in these rural communities—towns and small cities like Moab, St. George, Green River, Blanding, Beaver and Vernal—deserve access to the same services that are available to Medicare beneficiaries living in Salt Lake City, or for that matter, New York City.

I cannot criticize colleagues who are concerned that the new private sector-oriented delivery mechanisms we have designed in S. 1 may not be available to beneficiaries in rural areas. That being said, I want to provide assurances to my colleagues that the Committee worked hard to design a plan that would protect the elderly and disabled who reside in rural areas.

Indeed, it is not surprising that criticisms have been expressed that there could be gaps in coverage in rural areas given the experience with Medicare+Choice and Medicare HMOs.

These Medicare+Choice plans were established with the intent of providing Medicare beneficiaries throughout the country with access to both traditional Medicare and Medicare+Choice plans.

Unfortunately, it has not worked out that way. For a variety of reasons, the companies responsible for these plans found that they could not offer services in all areas.

Not surprisingly, many of the communities that were left without access to these HMOs are in rural areas.

I am particularly sensitive to this, because Utah is one of those States in which the Medicare+Choice plan operated for one year and then chose to discontinue.

This was a great disappointment to all—beneficiaries, the provider, and the Government alike.

So I, among all others, find it completely understandable that there may be a question about whether the plans will be available in rural communities.

I have a simple answer to that question. The new private drug plans created in A. 1 are completely different from the Medicare+Choice model.

We have learned from our experience with Medicare+Choice and we have worked to ensure we do not repeat past mistakes.

Let me take this opportunity to explain how the program will work.

Our legislation establishes a new Center for Medicare Choices within the Department of Health and Human Services. This new Center will be headed by an administrator who will oversee both the new drug plan and the new Medicare Advantage program.

To operate the prescription drug plan, the new administrator will create at least 10 regions throughout the country. These regions must be at least the size of a State.

If beneficiaries remain in the traditional Medicare program, they may receive pharmaceutical assistance through a new stand-alone program certified by the Government to provide coverage in that region. S. 1 requires that at least two stand-alone drug plans would be offered to Medicare beneficiaries in each region.

Now some may ask, ''How does that ensure rural Medicare beneficiaries will have access to prescription drugs distributed by private companies? How is this different from the Medicare+Choice HMOs?''

The answer is this.

The Medicare+Choice program is organized by counties. In other words, Medicare+Choice plans can choose to offer coverage in one county, but not in another.

These plans may ''cherry pick,'' or choose to operate in the more lucrative areas, ignoring the less profitable ones. For example, they can offer coverage in suburban counties where the cost of doing business might be lower or in counties where, for one reason or another, Medicare beneficiaries are healthier.

Under the new program, plans offering stand-alone prescription drug coverage will not be able to cherry pick in this way, because they must operate in all areas of a much larger region.

If a plan wants to offer coverage in Salt Lake City, it will be required to offer coverage in St. George, Moab, Beaver, Vernal, and Green River. In order to provide coverage in Salt Lake City, a plan will be required to offer coverage in every county and every community and to every Medicare beneficiary in Utah. That is true of other states and their rural problems as well. I am naturally talking about my own home State of Utah but it applies throughout the country.

We envision these regions, in many cases, encompassing more than one state, and combining rural areas and urban areas.

Medicare+Choice does not work this way. And so, we have designed the plans envisioned under S. 1 based on the lessons learned with Medicare+Choice.

Another criticism some in this body have voiced relates to the concern that prescription drugs might be available in a predominantly rural region, but with higher premiums for Medicare beneficiaries living in rural areas.

Once again, the concept of regions addresses this issue. Plans will be required to charge the same premium for an option throughout the region.

Let me add, however, that this does not ensure premiums will be identical between regions.

This important issue was raised during the Finance Committee's consideration of this legislation by my friend and colleague, Senator OLYMPIA SNOWE.

In order to address this very valid concern, our legislation gives the Secretary of Health and Human Services the discretion to make adjustments in geographic regions so there will not be a large discrepancy in Medicare prescription drug premiums across the country.

Other may wonder why we establish regions at all. Why not have a single premium throughout the country and private entities would bid to provide prescription drugs nationwide?

One reason we did choose this approach is that only a few private entities are currently able to provide nationwide coverage. Limiting competition to those few companies would neither ensure beneficiaries the best prescription drug prices nor a significant choice among coverage options.

The approach we have chosen is one that ensures beneficiaries will have access to prescription drug coverage. It provides for competition, and minimizes regional differences in beneficiary premium costs.

But some may still wonder whether private plans will choose to enter predominantly rural States or regions?

My Finance Committee colleagues and I have worked hard to ensure that plans have the appropriate incentives to participate in all 50 states.

Even so, no one can guarantee with complete certainty that private prescription drug plans will choose to operate in all of the States all of the time.

For this reason, we worked very hard to make certain there is a safety net, a ''fallback'' plan that would provide seniors with the coverage they need in the event only one or even no private sector plans enter a region.

If only one plan, or even if no plans, are willing to offer stand-alone prescription drug coverage within a region, the government will enter into an annual contract with an entity to provide a prescription drug fallback plan.

This fallback plan would be given a one year contract to offer the standard drug plan to all Medicare Part D beneficiaries in the region. The fallback plan will be an insurance policy provided by the federal government to ensure that Medicare beneficiaries in rural communities have prescription drug coverage available in the event that private plans are slow to begin providing service in their area.

Some in this body argue that if the fallback option is so attractive we should make it available all the time to anyone who wants it. Indeed, these colleagues argue that this so-called ''permanent fallback'' should be offered to beneficiaries in addition to the private stand-alone drug plans that would be offered to those Medicare beneficiaries remaining in traditional Medicare.

While this may sound attractive at first, it is not.

Making the fallback plan a permanent option will undermine the very structure upon which we have built S. 1.

Not only would it drastically increase costs—thus pushing the bill over the $400 billion 10-year limit—it would also be a disincentive for private plans to enter the market.

I will oppose any amendment that will make the fallback plan permanent.

First and foremost, including a permanent fallback plan creates an uneven playing field.

The government fallback is a non-risk bearing entity which means that it will operate in regions without any risk for gains or losses. The government pays the fallback plan for the administrative costs associated with delivering the drug benefit.

If we make the fallback plan permanent, we are basically requiring privately delivered drug plans, which are at least partially responsible for bearing the risk of delivering this benefit, to enter this same market and compete with these government fallback plans.

I think this is not only unfair, but it also sets up our drug plan for failure. There isn't a private health plan out there that will enter such a lopsided market where we give their competitors such a large financial advantage.

In addition, including a permanent fallback plan will add billions of dollars to the cost of this bill because we will be relying, at least partially, on an inefficient, more costly government-style delivery system to provide beneficiaries with drug coverage.

When the Senate was debating the Medicare prescription drug issue last year, this was one of the biggest criticisms against the drug benefit plan offered by our colleague from Florida, Senator GRAHAM.

The Graham drug benefit plan created a one-size-fits-all drug benefit delivered by the federal government. This is not what Medicare beneficiaries want. Beneficiaries want choice in drug coverage. They do not want to be forced into government-run plans and offered a one-size fits all benefit.

The intent of S. 1 is to introduce a new model to deliver care to Medicare beneficiaries.

We are harnessing the efficiencies and quality of a private-delivery system in order to offer Medicare beneficiaries a meaningful drug benefit. This drug benefit will include multiple choices, but it only works when all options are expected to participate under the same rules.

In S. 1, we included the government fallback as a safety net to ensure that every senior or disabled beneficiary has access to prescription drug coverage, but it is a fallback of last resort. And that is because even the Congressional Budget Office estimates that it is a more costly, less efficient model to deliver care.

I urge my colleagues to remember these points when the Senate considers an amendment that would make the fallback plan a permanent option under the stand-alone drug plans.

Let me make one thing perfectly clear. The stand-along benefit offered under Medicare Part D will not be the only way in which Medicare beneficiaries in rural areas can obtain prescription drug coverage.

In addition, the Medicare Advantage plans—including the current HMOs and new preferred provider organizations, called PPOs—will offer beneficiaries comprehensive, integrated coverage, including coverage for hospital services, outpatient care, and prescription drugs.

Private sector entities will bid to become one of three PPO plans in a region.

And, HMOs can continue to contract to provide all Medicare services—including drugs—for a county.

My Finance Committee colleagues and I have worked very hard to provide appropriate incentives to encourage the preferred provider organizations to participate in every region and in every State, whether they are predominantly rural or urban. However, if for some reason, PPOs decide not to bid in a specific region, the beneficiaries in these regions still will have the option to obtain prescription drug coverage through traditional Medicare and the new Medicare Part D plans that I described earlier.

The bill that we approved in committee provides options for Medicare beneficiaries in urban and rural areas to obtain prescription drugs through traditional Medicare and the new Part D prescription drug program, or through the new Medicare Advantage program with its comprehensive health care coverage plans.

Furthermore, the ''Prescription Drug and Medicare Improvement Act of 2003'' ensures all Medicare beneficiaries that prescription drug coverage will be available even if private entities are unable to provide the coverage in their region.

This legislation is preferable to previous bills we have considered, because it provides Medicare beneficiaries with more choices and more comprehensive coverage. It provides private entities with more incentives to cover rural communities, and it assures Medicare beneficiaries who live in those rural communities that they will have access to prescription drug coverage.

Just think of what we are doing here. We have a drug benefit that will begin

January 1, 2006, and it is a voluntary program.

We will issue a prescription drug card which will be offered to beneficiaries from January 1, 2004, through at least January 1, 2006, 6 months after the prescription drug benefit plan is implemented. The prescription drug plan will be implemented on January 1, 2004.

The drug benefit with the Medicare Part D is a Medicare Program. At least two stand-alone drug plans must be offered in each region. All Medicare beneficiaries will be able to participate. Those who remain in traditional Medicare will have a drug benefit equal to those who go into the new Medicare Advantage Program, formerly known as Medicare+Choice. Beneficiaries will be offered either standard drug coverage or drug coverage that is an actuarial equivalent to the standard drug plan. Either drug plan will be available to those remaining in traditional Medicare or those who begin the Medicare Advantage Program, this new program.

The national average of monthly premiums for the drug benefit will be $35 per month in 2006. All drug plans will have mandatory deductibles and beneficiary out-of-pocket cost-sharing limits.

Every beneficiary will have a choice between three prescription drug plans. The Medicare Advantage Program will offer either a PPO option or an HMO option. A stand-alone drug benefit will be offered to beneficiaries remaining in traditional Medicare. A maximum of three Medicare Advantage PPO plans will be offered per region. They will compete for the opportunity and the privilege of serving the people in that particular region. Health and Human Services will certify all of these drug plans before they are offered to Medicare beneficiaries. In any event, they will be offered to all Medicare beneficiaries, seniors and disabled.

I was a member of the tripartisan group last year that put forth the tripartisan plan. Had we not done that, we wouldn't be as far along today as we are. I have to say I was proud to be a member of that tripartisan plan, along with Senators GRASSLEY, SNOWE, BREAUX, and JEFFORDS. There were five of us. We took on that assignment, and we came up with a lot of ideas that have been improved upon in this bill. This was a very important bill.

There is no easy solution in these areas. In spite of the desire of some to have simple private sector solutions, those are not in the cards with the votes we have in the Senate today or in the near future, I have to say as well.

This bill is as close as we can go towards having two completely different but nevertheless useful options: traditional Medicare for those who do not want to leave, but this new Medicare Advantage for those who really want to try something different where they may have advantageous benefits over time.

We believe the competition fostered by this bill is going to be good competition, that it should help to keep costs down. But, most importantly, we believe all seniors should have a right to prescription drug benefits, and this plan will give it to them.

We will have lots of crying and moaning and groaning about different ideas around here, some of which I might like just as much as what we have in here, but we could not get them done. So we have come together in the art of the doable to get a bill that literally gives both sides of these options a chance to be able to excel and do better for our senior citizens. That is important. That is real important. This bill is important. It is the first time in history we have done this. Frankly, a $400 billion bill over 10 years is a very important bill that will do an awful lot of good for our seniors and for those who really are hard up in our society and for those who have to do without food or split their pills or do any number of things in order to be able to get the medications they need.

I am proud of this bill. Each one of us probably could, if we were dictators, come up with what we think might even be a better bill. But, fortunately, that isn't the way this representative republic works. We have to work within the framework of the Congress. Sometimes that is a messy, mixed up, sometimes very inefficient method of legislating, but, in the end, this country has survived because we have the greatest form of government in the history of the world. And this process, as sloppy as it might be from time to time is bringing about a bill that will do an awful lot of good for an awful lot of seniors in our society at a time when they need it the most.

I just hope we can reduce the number of amendments and get this bill passed as soon as we can, get together with the House in a conference, and, of course, come up with a final package that, hopefully, will even be improved that will take us throughout this next century in a way that will protect our seniors and those who have suffered for want of pharmaceutical prescription drugs.

I yield the floor.

The PRESIDING OFFICER (Mr. ALEXANDER). The Senator from Arizona.

Mr. MCCAIN. Mr. President, I ask unanimous consent to address the Senate as in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The remarks of Mr. MCCAIN pertaining to the submission of S. Res. 173 are printed in today's RECORD under ''Statements on Submitted Resolutions.'')

The PRESIDING OFFICER. The Senator from Kentucky is recognized.

Mr. MCCAIN. Mr. President, I note the presence of the Senator from Kentucky. I ask unanimous consent to engage him in a 2- or 3-minute dialog.

The PRESIDING OFFICER. Without objection, it is so ordered.

RELEASE OF AUNG SAN SUU KYI

Mr. MCCAIN. Mr. President, I am pleased to note that, thanks to the efforts of millions of people all over the world, ASEAN, in a radical departure from their previous practice, has called for the release of Aung San Suu Kyi. I thank the Senator for his sponsorship of the legislation that I think may have had some beneficial effect. We obviously don't know all the factors that went into it, except to note also that people all over the world have been aroused on behalf of this great and truly good person. I thank the Senator from Kentucky for his efforts on her behalf.

Mr. MCCONNELL. I thank the Senator from Arizona. I think he is the only person I know who has actually been in the presence of Suu Kyi. I am sure the Senator shares my view that the mere act of letting her out is a long way from where the two of us hope they will end up.

What the junta needs to do is a lot more than simply end the house arrest, but give her and her duly elected party an opportunity to assume the power that they won 13 years ago in an honest election. So it is a step in the right direction. I am sure my friend from Arizona agrees that we have a long way to go.

Mr. MCCAIN. I thank the Senator.

Mr. MCCONNELL. Mr. President, I was just going to wrap up. I see my friend from Alaska here. How long does the Senator expect to speak?

Mr. STEVENS. I really could not say.

Mr. MCCONNELL. May I do the wrap-up and then allow the Senator from Alaska to make his comments? The wrap-up is rather short, I believe.

Mr. STEVENS. May I inquire, did the Senator from Kentucky just cosponsor that amendment?

Mr. MCCONNELL. No. Mr. President, I did not cosponsor the amendment. We were just talking about Burma. Senator MCCAIN and I were talking about Burma. The expression on the face of the Senator from Alaska was one of alarm. I want to reassure him that I certainly did not cosponsor the resolution.

MORNING BUSINESS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Senate proceed to a period for morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

LET'S NOT FORGET CAMBODIA

Mr. MCCONNELL. Mr. President, Secretary of State Colin Powell is in Phnom Penh, Cambodia, for an annual ASEAN meeting. There are many issues he needs to pursue with ASEAN members, including, most urgently, support for the struggle for freedom in Burma.

Also pressing is the fate of democracy in Cambodia. Secretary Powell